

AGENCY NAME - ADDRESS
PHONE NUMBER - FAX NUMBER

COMMUNITY FIRST CHOICE PERS REFERRAL

➤ Plan Facilitator Name: _____ Phone #: _____

CFC Referral ☐ CFC Amendment ☐ Change CFC PERS Provider ☐ Service Termination ☐

This is to notify you that the member named below has chosen a Personal Emergency Response System from you.

PERS Provider: _____ Provider Medicaid ID# _____

Member Name: _____

Member Phone No: _____

Member Medicaid ID# _____ Member Birth Date: _____

Address: _____

Physician: _____ Phone No: _____

Primary Diagnosis: _____ Diagnosis Code: _____

Prior Authorization#: _____ Date Span: _____

Service	Procedure Code	Mod	Current Units	Corrected Units	Rate	Effective Date
PERS Installation	S5160					
PERS Rental	S5161					

Comments:

Notification of Service Termination:

PERS Provider

Termination Date

Member Name

Date